

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-045337

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 3446

FILED DEC 3 1962

1. PLACE OF DEATH a. COUNTY <u>ST. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Ferguson</u>		Length of stay in 1b <u>YRS.</u>	c. CITY OR TOWN <u>Ferguson</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>1515 Nesbit</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>1515 Nesbit</u>
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>LANG</u> Last			4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1874</u>	9. AGE (last birthday) <u>88</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>Perryville, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA.</u>		13a. FATHER'S NAME <u>Not Known</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>	
14. NAME OF HUSBAND OR WIFE <u>CHAS H LANG</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Muriel Burch</u>		Address <u>1515 Nesbit</u>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral malacia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Gen. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One yr</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>4:50</u> p.m. Month, Day, Year <u>Mar 20 1959</u>		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Mar 20 1959</u>		20f. CITY, TOWN, OR LOCATION <u>Nov 24 62</u>	
20g. COUNTY <u>Nov 25 62</u>		20h. STATE <u>Nov 25 62</u>	
21. I attended the deceased from <u>Mar 20 1959</u> to <u>Nov 24 62</u> and last saw her alive on <u>Nov 25 62</u> Death occurred at <u>4:50</u> p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>[Signature]</u>	22b. ADDRESS <u>206 Northland Med Bldg</u>	22c. DATE SIGNED <u>11-26-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-26-1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem</u>	23d. LOCATION (City, town, or county) (State) <u>ST. Louis Co Mo</u>
24. FUNERAL DIRECTOR <u>SULLIVAN-MUCKLE-KRON MORTUARY</u> 8806 JENNINGS ROAD		25. DATE RECD. BY LOCAL REG. <u>11-26-62</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

INSTEAD OF

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

DATE AMENDED

VS 300
Rev. 4/59

14009

24009

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9332X

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1290-0

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Albert Mayfield

Licensed Embalmer No. 3077

P. O. Address St. Louis Mo

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.